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8 **BEFORE THE**
9 **BOARD OF REGISTERED NURSING**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

12 In the Matter of the Accusation Against:

Case No. 2010-72

13 **TERRY SCOTT DAVIS**
14 **1403 Jay Street**
15 **Walnut Ridge, Arkansas 72476**
16 **Registered Nurse License No. 612749**

A C C U S A T I O N

Respondent.

17 Complainant alleges:

PARTIES

18 1. Louise R. Bailey, M.Ed., RN, ("Complainant") brings this Accusation solely in her
19 official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"),
20 Department of Consumer Affairs.

Registered Nurse License

21 2. On or about January 30, 2003, the Board issued Registered Nurse License Number
22 612749 to Terry Scott Davis ("Respondent"). The registered nurse license expired on August 31,
23 2008.

STATUTORY PROVISIONS

24 3. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent
25 part, that the Board may discipline any licensee, including a licensee holding a temporary or an
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1 inactive license, for any reason provided in Article 3 (commencing Code with section 2750) of
2 the Nursing Practice Act.

3 4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not
4 deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or
5 to render a decision imposing discipline on the license. Under Code section 2811, subdivision
6 (b), the Board may renew an expired license at any time within eight years after the expiration.

7 5. Code section 2761 states, in pertinent part:

8 The board may take disciplinary action against a certified or licensed
9 nurse or deny an application for a certificate or license for any of the following:

10 (a) Unprofessional conduct, which includes, but is not limited to, the
11 following:

12 (f) Conviction of a felony or of any offense substantially related to the
13 qualifications, functions, and duties of a registered nurse, in which event the record of
14 the conviction shall be conclusive evidence thereof.

15 6. Code section 2762 states, in pertinent part:

16 In addition to other acts constituting unprofessional conduct within the
17 meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a
18 person licensed under this chapter to do any of the following:

19 (a) Obtain or possess in violation of law, or prescribe, or except as
20 directed by a licensed physician and surgeon, dentist, or podiatrist administer to
21 himself or herself, or furnish or administer to another, any controlled substance as
22 defined in Division 10 (commencing with Section 11000) of the Health and Safety
23 Code or any dangerous drug or dangerous device as defined in Section 4022.

24 (c) Be convicted of a criminal offense involving the prescription,
25 consumption, or self-administration of any of the substances described in
26 subdivisions (a) and (b) of this section, or the possession of, or falsification of a
27 record pertaining to, the substances described in subdivision (a) of this section, in
28 which event the record of the conviction is conclusive evidence thereof.

(e) Falsify, or make grossly incorrect, grossly inconsistent, or
unintelligible entries in any hospital, patient, or other record pertaining to the
substances described in subdivision (a) of this section.

COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the
administrative law judge to direct a licensee found to have committed a violation or violations of
the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
enforcement of the case.

1 8. Code section 4060 states, in pertinent part:

2 "No person shall possess any controlled substances, except that furnished to a person upon
3 the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic
4 doctor...."

5 9. Health and Safety Code section 11173, subdivision (a) provides that no person shall
6 obtain or attempt to obtain controlled substances, or procure or attempt to procure the
7 administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation,
8 or subterfuge; or (2) by the concealment of a material fact.

9 10. **DRUGS**

10 "Dilaudid," a brand of hydromorphone, is a Schedule II controlled substance as designated
11 by Health and Safety Code section 11055, subdivision (b)(1)(K), and a dangerous drug under
12 Code section 4022 in that under federal or state law it requires a prescription.

13 "Morphine" is a Schedule II controlled substance as designated by Health and Safety Code
14 section 11055, subdivision (b)(1)(M), and a dangerous drug under Code section 4022 in that
15 under federal or state law it requires a prescription.

16 **FIRST CAUSE FOR DISCIPLINE**

17 **Criminal Conviction**

18 11. Respondent is subject to discipline pursuant to 2761, subdivision (f), in that on
19 September 15, 2008, in the Superior Court, County of Solano, California, in the matter entitled
20 *People vs. Terry Scott Davis* (2008), Case No. FCR254558, Respondent was convicted by the
21 court following his plea of nolo contendere to a violation of Health and Safety Code section
22 11173, subdivision (a) (obtaining controlled substance by fraud), and Penal Code section 487,
23 subdivision (a)/503 (grand theft by embezzlement), both felonies. The circumstances of the crime
24 are that between December 8, 2006, and January 7, 2007, Respondent obtained controlled
25 substances by fraud from Northbay Medical Center, where he was employed at the time.

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1 f. Between May 25, 2004, and October 15, 2004, Respondent possessed the controlled
2 substances Dilaudid and Morphine in violation of Code section 4060.

3 **FOURTH CAUSE FOR DISCIPLINE**

4 **(Falsify Patient and/or Hospital Records)**

5 14. Respondent is subject to discipline pursuant to Code section 2762, subdivision (e), for
6 unprofessional conduct, in that while on duty as a registered nurse at various facilities in
7 California, Respondent falsified or made grossly incorrect, inconsistent, or unintelligible entries
8 in the following hospital and patient records:

9 **Northbay Medical Center**

10 **Patient F**

11 a. On January 3, 2007, at 2329 hours, Respondent withdrew two 2 mg vials of
12 Hydromorphone from the Pyxis System for this patient; however, there was no physician's order
13 for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the
14 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
15 drug.

16 b. On January 4, 2007, at 0235 hours, Respondent withdrew two 2 mg vials of
17 Hydromorphone from the Pyxis System for this patient; however, there was no physician's order
18 for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the
19 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
20 drug.

21 c. On January 4, 2007, at 2321 hours, Respondent withdrew two 2 mg vials of
22 Hydromorphone from the Pyxis System for this patient; however, there was no physician's order
23 for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the
24 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
25 drug.

26 d. On January 5, 2007, at 0428 hours, Respondent withdrew one 2 mg vial of
27 Hydromorphone from the Pyxis System for this patient; however, there was no physician's order
28 for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the

1 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
2 drug.

3 e. On January 5, 2007, at 0904 hours, Respondent withdrew two 2 mg vials of
4 Hydromorphone from the Pyxis System for this patient; however, there was no physician's order
5 for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the
6 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
7 drug.

8 f. On January 5, 2007, at 1542 hours, Respondent withdrew two 2 mg vials of
9 Hydromorphone from the Pyxis System for this patient; however, there was no physician's order
10 for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the
11 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
12 drug.

13 Patient E

14 a. On December 26, 2006, at 0516 hours, Respondent withdrew one 2 mg vial of
15 Hydromorphone from the Pyxis System for this patient; however, there was no physician's order
16 for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the
17 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
18 drug.

19 b. On December 26, 2006, at 2317 hours, Respondent withdrew two 2 mg vials of
20 Hydromorphone from the Pyxis System for this patient; however, there was no physician's order
21 for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the
22 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
23 drug.

24 c. On December 26, 2006, at 2341 hours, Respondent withdrew two 2 mg vials of
25 Hydromorphone from the Pyxis System for this patient; however, there was no physician's order
26 for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the
27 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
28 drug.

1 d. On December 27, 2006, at 0514 hours, Respondent withdrew one 2 mg vial of
2 Hydromorphone from the Pyxis System for this patient; however, there was no physician's order
3 for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the
4 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
5 drug.

6 e. On December 28, 2006, at 1510 hours, Respondent withdrew one 2 mg vial of
7 Hydromorphone from the Pyxis System for this patient; however, there was no physician's order
8 for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the
9 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
10 drug.

11 Patient C

12 f. On January 6, 2007, at 0217 hours, Respondent withdrew two 2 mg vials of
13 Hydromorphone from the Pyxis System for this patient; however, there was no physician's order
14 for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the
15 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
16 drug.

17 g. On January 6, 2007, at 0551 hours, Respondent withdrew two 2 mg vials of
18 Hydromorphone from the Pyxis System for this patient; however, there was no physician's order
19 for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the
20 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
21 drug.

22 h. On January 7, 2007, at 0731 hours, Respondent withdrew one 2 mg vial of
23 Hydromorphone from the Pyxis System for this patient; however, there was no physician's order
24 for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the
25 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
26 drug.

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Patient B

i. On January 4, 2007, at 0510 hours, Respondent withdrew one 2 mg vial of Hydromorphone from the Pyxis System for this patient; however, there was no physician's order for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the Hydromorphone in any patient/hospital record or otherwise account for the disposition of the drug.

j. On January 4, 2007, at 0624 hours, Respondent withdrew one 2 mg vial of Hydromorphone from the Pyxis System for this patient; however, there was no physician's order for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the Hydromorphone in any patient/hospital record or otherwise account for the disposition of the drug.

k. On January 4, 2007, at 0704 hours, Respondent withdrew one 2 mg vial of Hydromorphone from the Pyxis System for this patient; however, there was no physician's order for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the Hydromorphone in any patient/hospital record or otherwise account for the disposition of the drug.

l. On January 5, 2007, at 0642 hours, Respondent withdrew one 2 mg vial of Hydromorphone from the Pyxis System for this patient; however, there was no physician's order for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the Hydromorphone in any patient/hospital record or otherwise account for the disposition of the drug.

m. On January 5, 2007, at 1233 hours, Respondent withdrew one 2 mg vial of Hydromorphone from the Pyxis System for this patient; however, there was no physician's order for Hydromorphone for this patient. Respondent failed to chart the wastage of any portion of the Hydromorphone in any patient/hospital record or otherwise account for the disposition of the drug.

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1 Patient A

2 n. On December 28, 2006, at 0156 hours, Respondent withdrew two 2 mg vials of
3 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
4 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
5 otherwise account for the disposition of the drug.

6 o. On December 28, 2006, at 1214 hours, Respondent withdrew one 2 mg vial of
7 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
8 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
9 otherwise account for the disposition of the drug.

10 Patient D

11 n. On December 8, 2006, at 1551 hours, Respondent withdrew one 2 mg vial of
12 Hydromorphone from the Pyxis System for this patient, charted the administration of 0.5 mg of
13 Hydromorphone in the patient's Medication Administration Record however, Respondent failed
14 to chart the administration or wastage of the remaining 1.5 mg of Hydromorphone in any
15 patient/hospital record or otherwise account for the disposition of the drug.

16 o. On December 9, 2006, at 0430 hours, Respondent withdrew one 2 mg vial of
17 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
18 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
19 otherwise account for the disposition of the drug.

20 p. On December 9, 2006, at 0901 hours, Respondent withdrew one 2 mg vial of
21 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
22 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
23 otherwise account for the disposition of the drug.

24 q. On December 21, 2006, at 2317 hours, Respondent withdrew one 2 mg vial of
25 Hydromorphone from the Pyxis System for this patient, charted the administration of 0.25 mg of
26 Hydrocodone in the patient's Medication Administration Record; however, Respondent failed to
27 chart the administration or wastage of any portion of the remaining Hydromorphone in any
28 patient/hospital record or otherwise account for the disposition of the drug.

1 r. On December 28, 2006, at 0557 hours, Respondent withdrew one 1 mg vial of
2 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
3 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
4 otherwise account for the disposition of the drug.

5 s. On December 28, 2006, at 1044 hours, Respondent withdrew one 1 mg vial of
6 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
7 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
8 otherwise account for the disposition of the drug.

9 t. On January 3, 2007, at 0600 hours, Respondent withdrew one 2 mg vial of
10 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
11 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
12 otherwise account for the disposition of the drug.

13 u. On January 5, 2007, at 0004 hours, Respondent withdrew one 1 mg vial of
14 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
15 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
16 otherwise account for the disposition of the drug.

17 v. On January 5, 2007, at 0232 hours, Respondent withdrew one 2 mg vial of
18 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
19 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
20 otherwise account for the disposition of the drug.

21 w. On January 5, 2007, at 0543 hours, Respondent withdrew one 1 mg vial of
22 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
23 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
24 otherwise account for the disposition of the drug.

25 x. On January 5, 2007, at 0544 hours, Respondent withdrew one 2 mg vial of
26 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
27 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
28 otherwise account for the disposition of the drug.

1 **Alta Bates Summit Medical Center**

2 Patient B/C

3 y. On October 28, 2004, at 1810 hours, Respondent withdrew one 2 mg vial of
4 Hydromorphone from the Pyxis System for this patient; however, this patient did not have a
5 physician's order for Hydromorphone. Respondent failed to chart the wastage of the
6 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
7 drug.

8 z. On October 28, 2004, at 2043 hours, Respondent withdrew one 2 mg vial of
9 Hydromorphone from the Pyxis System for this patient; however, this patient did not have a
10 physician's order for Hydromorphone. Respondent failed to chart the wastage of the
11 Hydromorphone in any patient/hospital record or otherwise account for the disposition of the
12 drug.

13 Patient D

14 aa. On October 29, 2004, at 0000 hours, Respondent withdrew one 2 mg vial of
15 Hydromorphone from the Pyxis System for this patient; however, this patient did not have a
16 physician's order for Hydromorphone. Further, the patient was discharged two hours prior to this
17 medication withdrawal. Respondent failed to chart the wastage of the Hydromorphone in any
18 patient/hospital record or otherwise account for the disposition of the drug.

19 Patient E

20 bb. On October 29, 2004, at 0225 hours, Respondent withdrew two 2 mg vials of
21 Hydromorphone from the Pyxis System for this patient; however, this patient did not have a
22 physician's order for Hydromorphone. Further, the patient was discharged six hours prior to this
23 medication withdrawal. Respondent failed to chart the wastage of the Hydromorphone in any
24 patient/hospital record or otherwise account for the disposition of the drug.

25 Patient F

26 cc. On October 28, 2004, at 2045 hours, Respondent withdrew one 2 mg vial of
27 Hydromorphone from the Pyxis System for this patient; however, this patient did not have a
28 physician's order for Hydromorphone. Further, the patient was discharged eight hours prior to

1 this medication withdrawal. Respondent wasted 1.5 mg of the drug with a witness; however,
2 Respondent failed to account for the disposition of the remaining 0.5 mg of Hydromorphone.

3 **Doctors Medical Center-San Pablo**

4 Patient Account/Medical No. 3084469

5 dd. On October 17, 2004, at 7:09 p.m., Respondent withdrew one 2 mg vial of
6 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
7 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
8 otherwise account for the disposition of the drug.

9 ee. On October 18, 2004, at 1:11 a.m., Respondent withdrew one 2 mg vial of
10 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
11 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
12 otherwise account for the disposition of the drug.

13 ff. On October 20, 2004, at 7:49 p.m., Respondent withdrew one 2 mg vial of
14 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
15 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
16 otherwise account for the disposition of the drug.

17 gg. On October 20, 2004, at 11:15 p.m., Respondent withdrew one 2 mg vial of
18 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
19 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
20 otherwise account for the disposition of the drug.

21 hh. On October 21, 2004, at 3:53 a.m., Respondent withdrew one 2 mg vial of
22 Hydromorphone from the Pyxis System for this patient; however, Respondent failed to chart the
23 administration or wastage of any portion of the Hydromorphone in any patient/hospital record or
24 otherwise account for the disposition of the drug.

25 Patient Account/Medical No. 2037742

26 ii. On May 25, 2004, at 0010 hours, 0301 hours, and 0502 hours, Respondent withdrew
27 one 2 mg vial of Hydromorphone each time, from the Pyxis System for this patient; however,
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Respondent failed to chart the administration or wastage of any portion of the Hydromorphone in any patient/hospital record or otherwise account for the disposition of the drug.

Patient Account/Medical Nos. 3202097/1071361

jj. On October 15, 2004, at 1333 hours, Respondent withdrew 4 mg of Hydromorphone from the Pyxis System for this patient; however, the patient died two days earlier, on October 13, 2004. Respondent failed to chart the wastage of any portion of the Hydromorphone in any patient/hospital record or otherwise account for the disposition of the drug.

Patient Account/Medical No. 3089819


kk. On September 30, 2004, at 2038 hours, Respondent withdrew one 2 mg syringe of Morphine from the Pyxis System for this patient; however, the patient already had an order for a Morphine PCA (patient controlled analgesic). Respondent failed to chart the administration or wastage of any portion of the Morphine in any patient/hospital record or otherwise account for the disposition of the drug.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 612749, issued to Terry Scott Davis Terry Scott Davis.
2. Ordering Terry Scott Davis to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,
3. Taking such other and further action as deemed necessary and proper.

DATED: 8/11/09


LOUISE R. BAILEY, M.Ed., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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